

OVERVIEW

Transition Intensive Support Coordination (TISC) assists individuals currently residing in nursing facilities who want to transition into the community. This service assists individuals in gaining access to needed waiver and Medicaid State Plan services, as well as needed medical, social, educational and other services such as housing, regardless of the funding source.

For the purpose of this policy, when referring to “individuals”, this includes “personal representatives, legal guardians and/or family members”, when applicable and appropriate.

SERVICE EXCLUSION

Support coordination agencies will not bill for this service until after the individual has been approved for the EDA Waiver.

The scope of TISC does not overlap with the scope of Support Coordination (SC); therefore, duplicate billing will not occur.

SERVICE LIMITATIONS

SC agencies may be retroactively reimbursed for up to four (4) months prior to the date the individual transitions from the nursing facility (NF). Reimbursement is contingent upon the SC performing activities necessary to arrange for the individual to live in the community. These activities must be documented by the SC. SC agencies will not receive reimbursement for any month during which no activity was performed and documented by the SC that assisted in the transition process.

PROCEDURE

For those individuals who reside in a NF at the time of their waiver offer, the data management contractor will mail the EDA Waiver offer to the individual in the nursing facility. If available records indicate that the individual has a designated personal representative, the data management contractor will also mail the EDA Waiver offer to the individual’s designated personal representative.

NOTE: Personal Representatives, persons with power of attorney/representative and mandate authority, and/or family members can not override the decision of the resident unless they are a court appointed legal guardian.

If the individual accepts the EDA Waiver offer:

- The individual will complete and return the offer forms or verbally convey acceptance and SC agency selection to the data management contractor for linkage.
- The data management contractor will notify the OAAS R.O., SC agency and local

Medicaid office of linkage.

- Once the individual is linked, the SC will contact the Eligibility Policy section in Medicaid state office, **by e-mail** and copy the OAAS R.O., to determine if the individual will meet Medicaid (financial) eligibility outside of the NF. Both the SC and the OAAS R.O. will be notified by return e-mail of the individual's financial eligibility status.

If the individual does not meet Medicaid financial eligibility outside of the NF:

- The Medicaid office will issue a denial letter giving appeal rights to the individual and copy OAAS R.O and the SC agency.
- Upon final disposition by Medicaid, OAAS R.O. will take action to close the case in accordance with established procedures.
- The SC will issue a closure 148-W and closure summary to OAAS R.O.
- Once fully processed by Medicaid, OAAS R.O. will sign closure 148-W and send copy of 148-W, closure summary and Medicaid denial letter to the data management contractor to close the EDA Waiver case.

NOTE: If the individual appeals the decision and wins, his/her EDA Waiver case will be reinstated.

If the individual continues to meet Medicaid financial eligibility outside of the NF the SC will proceed with the waiver application process as follows:

- Contact the individual within three (3) working days of notification of linkage to schedule the first face-to-face meeting for assessment purposes.
- Conduct a face-to-face meeting with the individual within ten (10) calendar days of receipt of the linkage notification to complete the assessment process including the Minimum Data Set – Home Care (MDS-HC) and explain the EDA Waiver and all available services. During this initial face-to-face meeting the SC will explain the following:
 - the level and type of supports available through the waiver;
 - the need for these paid supports to be supplemented with natural or other paid supports, since waiver services are not available 24 hours per day;
 - these supports do not cover ongoing costs for housing and other basic needs; and
 - the state is responsible for reasonably assuring the health and welfare of participants with provision of these paid supports in conjunction with natural and other paid supports.
- Meet with appropriate NF staff (i.e. Social Worker, Director of Nursing, etc.),

ombudsman and family, as applicable, to review records and gather information for determining if the individual's needs can be met. This information may include, but is not limited to:

- Does he/she have supplemental, natural and/or other paid supports available?
- Does he/she have housing?
- Does he/she have means for meeting other basic needs?

Sources of information may include but are not limited to: the ombudsman, the Minimum Data Set-Nursing Facility (MDS-NF), the MDS-HC, progress notes and orders from all applicable disciplines.

Once all assessment information is gathered, if it appears that the individual's health and welfare cannot be reasonably assured:

- Documentation supporting the inability to reasonably assure health and welfare will be put in a detailed narrative and forwarded to the OAAS R.O. A Comprehensive Plan of Care (CPOC) does not have to be completed or submitted. However, based on the information obtained through the assessment and other sources, the narrative should address the issues described above (i.e., housing, adequacy of paid and unpaid supports, etc.) in detail sufficient to document why it is not felt that transition is a viable option for the individual.
- OAAS R.O. will forward all information for review by the OAAS Service Review Panel (SRP).
- If the OAAS SRP determines that the individual's health and welfare cannot be reasonably assured, OAAS R.O. will send a denial letter.
- Upon receipt of a copy of OAAS R.O.'s denial letter, the SC will complete a discharge form 148-W and closure summary to include sufficient documentation to substantiate that health and welfare cannot be reasonably assured and forward to OAAS R.O.

Once all assessment information is gathered and all good faith efforts to secure housing for the individual have been exhausted and it appears that housing will not be available to the individual:

- Documentation supporting the inability to secure housing will be put in a detailed narrative and forwarded to the OAAS R.O. for review as to whether or not the individual's EDA Waiver slot is to be placed on inactive status*. A Comprehensive Plan of Care (CPOC) does not have to be completed or submitted. However, based on the information obtained through the assessment and other sources, the narrative should address the issues described above (i.e., housing, adequacy of paid and unpaid supports, etc.) in detail sufficient to document why it is not felt that transition is a viable option

for the individual.

*Inactive status is defined as follows: The individual is waiting for housing to become available after all good faith efforts have been exhausted and documented and approved by OAAS R.O.

- If OAAS R.O.'s review results in a determination that all good faith efforts to secure housing have been exhausted and documents and housing will not be available to the individual, the SC will be notified that the individual's Waiver slot is to be placed in inactive status* pending availability of housing.
- The SC will issue an inactive status letter advising the individual that transition activities will resume when housing becomes available.
- The SC will complete a discharge form 148-W and closure summary to include sufficient documentation to substantiate placement in inactive status and forward to OAAS R.O.
- OAAS R.O. will review either approve or not approve the discharge form 148-W and forward to the SC agency, local Medicaid office and the data management contractor.
- When housing becomes available the status of the individual's EDA Waiver slot will be changed from inactive to active and the SC will resume activities to transition the individual from the nursing facility.

Once all assessment information is gathered and it appears that the individual's health and welfare can be reasonably assured and housing is available, the SC will proceed with POC development as outlined below and in accordance with established procedures

NOTE: Individuals leaving a nursing facility are deemed, by their presence in the nursing facility, to meet nursing facility level of care and Imminent Risk criteria. They are eligible to transition to any home and community based services (HCBS) program if all program requirements are met for the desired HCBS program. Additionally, use of the MDS-HC for confirmation of level of care eligibility is also not required.

These individuals will be required to meet nursing facility level of care upon annual reassessment in accordance with established guidelines.

**In the event that a nursing facility resident is deemed to meet level of care eligibility because this eligibility is not otherwise established via assessment (e.g., LOCET and/or MDS-HC), the following statement is to be entered by support coordination agency staff in the Telesys MDS-HC notebook:
"Deemed to meet LOC eligibility due to current NF resident status"**

At and as a result of the Assessment and POC development meetings, the SC will:

- Develop the Plan of Care (POC) through a collaborative process involving the individual, family member(s) and personal representative. Other planning team members may include NF staff, ombudsmen, or other support systems, appropriate professionals and others whom the individual chooses to be involved.
- Assist the individual with locating housing (if applicable), including assisting with gathering, locating, and obtaining all necessary documents needed for the housing application.
- Identify the individual's community physician(s).
- Determine if transition services are needed. (If applicable – see Transition Service).
- Determine a preliminary/projected move date.
- Offer Freedom of Choice of DSPs, after the SC has identified the services needed for the individual.
- Forward information to the chosen DSP(s) for determination of whether or not that provider can meet the individual's needs.
- Complete the POC and submit to OAAS R.O. for review and pre-approval within thirty-five (35) calendar days of notification of linkage.
- Conduct at least a monthly face-to-face visit with the individual at the NF to ensure that transition efforts are ongoing and that any barriers are properly addressed.
- Visit the prospective residence prior to transitioning from the nursing facility.

The POC will:

- Identify all needs/services that will allow the individual to transition to and live in the community.
- Identify unpaid natural supports that will assist the individual.
- Identify transition services, if applicable.
- Identify a preliminary/projected move date.
- Include a transition plan that details what the individual will have/need as he/she transitions into the community, including housing.

- Include TISC service in the Supports and Services section and on the budget sheet reflecting the estimated cost.

The OAAS R.O. will:

- Review the POC packet.
- If additional information is needed, the POC will be returned to the SC.
- Complete a pre-certification visit to the individual at the NF and to the individual's prospective residence.
- If OAAS R.O. has any concerns regarding the individual's inability to transition and/or regarding whether or not health and welfare can be reasonably assured, he/she will refer for review by the OAAS Service Review Panel:
 - If OAAS determines that waiver services are not appropriate, a denial letter giving "adequate notice" of the decision with appeal rights will be mailed by OAAS R.O. to the individual and the SC will be notified. (If the individual appeals the decision, OAAS R.O. will follow the closure/appeal process identified below.)
 - If the individual appeals the decision and wins, his/her EDA Waiver case will be reinstated.

NOTE: The denial letter will cite the appropriate admission denial and discharge criteria outlined in the EDA Waiver rule.

- If OAAS R.O. pre-approves the POC, a form Pre-142 is completed and forwarded to the SC agency.

The SC will assist the individual (after notification of pre-approval) with the following, if applicable:

- Requesting individual's personal funds from the NF and opening a personal bank account for the individual, if he/she wishes;
- Making a list of all personal belongings to be transferred with the individual; and
- Arranging for DSP staff coverage, transportation for the individual on the date of discharge from the NF, and for transportation of the individual's personal belongings.

If Transition Service is identified and pre-approved in the POC, the SC will also assist with the following, as applicable:

- Assuring that all transition service expenses identified on the Transition Services Expense and Planning and Approval (TSEPA) form have been purchased and set-up in the individual's residence.

Once the individual has transitioned to his/her new residence, the SC will:

- Conduct a face-to-face visit with the individual at his/her new residence on the day of discharge from the NF to ensure that identified needs/services are in place;
- Inform OAAS R.O. that the individual has transitioned from the nursing facility for completion of the certification process with Medicaid and the prior authorization contractor in accordance with established procedures; and
- Assist the individual in changing the representative payee and/or address change for Social Security/Supplemental Security Income (SSI) and/or other benefits, if applicable.

NOTE: It is very important that the individual contact the local Social Security Administration office on the actual day of the move to avoid any delay in benefits.

PRIOR AUTHORIZATION and REIMBURSEMENT

- TISC is reimbursed at a monthly rate as set by Medicaid for a maximum of 4 months prior to the date of transition.
- Reimbursement will not be authorized until the OAAS R.O. gives final POC approval after receipt of the 18-W form from the local Medicaid office. The vendor payment date will be the date of the actual move from the NF.

NOTE: The vendor payment date cannot be prior to the date that the individual is discharged from the NF.

- TISC claims will require an override from the Medicaid Waiver Assistance and Compliance (WAC) section. The SC will submit a completed paper claim (CMS 1500), an Override Request form, the approval page of the approved POC, the budget page of the approved POC and all required documentation (e.g. progress notes, etc.) to OAAS R.O.
- OAAS R.O. will review all documents to make sure all requirements were met.
- If all SC requirements were met, OAAS R.O. will send the packet to the OAAS State Office Operations Provider Liaison.
- OAAS State Office Operations staff will forward to WAC for authorization to release payment.

- Once WAC approves the override, the entire packet will be returned to OAAS State Office Operations.
- OAAS State Office Operations staff will forward the approved packet to R.O.
- OAAS R.O. will notify the SC agency to proceed with billing.